Minutes of Meeting

Health Services Council

Project Review Committee-I

DATE: 25 September 2007 TIME: 3:00 PM

LOCATION: Conference Room C

Department of Administration

ATTENDANCE:

Committee-I: Present: Victoria M. Almeida, Esq. (Vice Chair), Edward F. Almon, John W. Flynn, Robert S.L. Kinder, M.D., Amy Lapierre, Thomas M. Madden, Esq., Robert J. Quigley, D.C. (Chair), Larry Ross

Not Present: Joseph V. Centofanti, M.D., Robert Ricci, Robert Whiteside

Committee-II: Present: Gary J. Gaube, Catherine E. Graziano, R.N.

Staff: Valentina Adamova, Michael K. Dexter, Chrystele Lauture (Intern), Joseph G. Miller, Esq., Christine Tice (Intern), Donald C. Williams

Public: (Attached)

1. Call to Order, Approval of Minutes, Conflict of Interest Forms and Time Extension for the Minutes Availability

The meeting was called to order at 3:00 PM. The Chairman noted that conflict of interest forms were available to any member who may have a conflict. The Chairman requested a motion for the extension of time for the availability of minutes pursuant to the Open Meetings Act. A motion was made, seconded and passed by a vote of eight in favor and none opposed (8-0) that the availability of the minutes for this meeting be extended beyond the time frame provided for under the Open Meetings Act. Those members voting in favor were: Almeida, Almon, Flynn, Kinder, Lapierre, Madden, Quigley, Ross.

2. General Order of Business

The first item on the agenda was the application of Kent County Memorial Hospital [Care New England Health System] to establish a primary angioplasty program to service patients with acute myocardial infarction.

Mr. Crevier, President and CEO, and Dr. Audett, Senior Vice President of Medical Affairs, from Kent Hospital presented a PowerPoint presentation. It was presented that that Kent hospital has the patient volume to warrant a need for the proposed services. Kent is the

second busiest hospital in Rhode Island with 60,000 annual emergency department visits. Kent also has a service area of over 300,000 people. The fixed costs of the proposed program are already in place and that the hospital will meet the ACC/AHA guidelines for Primary PCI hospitals (institutional resources, physician resources, and program requirements) without on-site cardiac surgery. This includes having Rhode Island Hospital as the designated back-up hospital if open-heart surgery is necessary. The applicant provided specific examples of how Kent will comply with each guideline.

The applicant noted that the cardiac care of all patients across central and southern Rhode Island would benefit from the Primary PCI program. There was discussion of the experienced angioplasty operators Kent already has, as well as the procedures that will be in place for RIH to assist in the training of nursing and technical staff. Support from RIH will help Kent meet their goal of a 90 minute door to balloon time for 75% of qualified patients.

The Chair asked if Kent was going to provide a contract with RIH that specifically maps out RIH's role in Kent's PCI program. The applicant answered yes. The Chair asked how many of the 400 MI's annually would require PCI's. The applicant explained that one-third of the 400 heart attacks are the right type of heart attack to qualify for a PCI, therefore, about 60 to 80 are eligible for the PCI. The Chair inquired if more people were diverted to Kent would the number if PCI's at Kent increase. The applicant answered that the potential for increased

volume is there but their projections were based on what the hospital has seen in the past.

Mr. Ross noted the application shows that up to 20% of eligible patients would not be able to receive the cardiac services because the cardiac lab is busy. Mr. Ross asked how Kent was going to deal with this issue. The applicant responded that there will be a degree of collaboration between the ER and the cardiac lab and the 20% was a worse case scenario and 10% is much more likely. It was also noted by the applicant that the conservative figures were used for the applicant so the minimum standards could be met.

Mr. Ross asked whether there is the possibility of creating a new cardiac catheterization lab to address this and if this would be in the possible future plans of Kent. The applicant responded that they are currently in the midst of long term strategic planning and moving the cardiac lab closer to the ER was in the possible plans. Mr. Ross asked if the RIH's physicians who would be performing emergency procedures related to the PCI procedure would be only be on call or would they would be on-site in any other capacity. The applicant responded that the physicians from RIH would mostly be called after hours and on weekends from their homes. Mr. Ross inquired regarding the hourly distribution of when people come in for primary PCI's. The applicant responded that about 60% of PCI's occur in the early morning hours or during off hours and that 20% of these patients would be in on off hours during the weekend.

Ms. Lapierre stated that the application shows that 100 patients qualify for PCI's or thrombolytic therapy. She asked what percent of these patient qualify for each procedure. The applicant responded that there are customarily more patients that use PCI's because there are usual bleeding complications with thrombolytic therapy. Patients would also be directed toward PCI, barring qualification issues, because it is a better therapy.

Mr. Gaube asked what percent of states allow emergent PCI without surgical backup. The applicant responded with about 40 states including neighboring states of Massachusetts and New Jersey.

Staff asked if the applicant's databases for outcomes are the same ones used by Lifespan. The applicant answered yes. Staff noted that of the 100 patients who qualify 40 do not get PCI. Staff asked if Kent could rectify these barriers for 40% of those who do not qualify. The applicant noted that the 40% number includes people who are not suited for the procedure. The applicant said it would work to overcome preventable barriers.

Mr. Madden asked why Kent had not filed this application earlier. The applicant stated that they were unable to file before due to regulatory requirements. They also noted that Rhode Island used to be more of thrombolytic state and just recently began using PCI more often.

Ms. Lapierre asked what percentage of people receiving PCI's usually need surgical backup and what usually are the outcomes of these procedures. The applicant responded that complication rates are less than 1%. The applicant noted that there would be protocols in place to transfer the patients. Ms. Lapierre asked whether outcomes are better for patients who receive emergency surgery on-site rather than after being transferred. The applicant responded that anyone needing emergency open-heart procedure has a relatively poor projected outcome.

Mr. Williams asked whether the need for emergency open-heart procedure is more prevalent in primary PCI cases or in planned ones. The applicant responded that there is no statistical difference that they are aware of.

Mr. Williams asked why the applicant is proposing to only perform primary PCI and not elective as well. The applicant replied that the risks and benefits of having no surgical backup are better when it comes to primary PCI. In other words, with no surgical backup in case of complications, it is better to take that risk in an emergency situation.

Mr. Williams asked whether the applicant would need a new or larger cardiac cath lab if approval is granted. The applicant relied that the cath lab is very busy and a case could be made for a second lab. If the emergent PCI goes well elective PCI may be in the future and at

that point a second lab may be needed. The applicant explained that some experience in the area of PCI's is needed first.

Staff noted to the Committee that the Department has contracted Mr. Zimmerman as consultant for this proposal and that he would be providing a report to address the issues of need, standards, percentages of outcomes, and the like with regard to primary PCI in Rhode Island. This report will help greatly in assessing the need for PCI sites in RI.

The Chair asked the applicant how it was going to handle the additional volume in the cardiac lab. The applicant said that the existing cardiac lab can is ready right now but in the near future new materials and machines will be needed to keep the cardiac lab updated. The applicant also noted that Kent is looking into moving the cardiac lab closer to the emergency room. The applicant responded that they would be making structural changes to accommodate the expanding behavioral health population.

The Chair invited all members of the Committee, as well as the members of Tertiary Care Advisory Committee, to come to a site visit of Rhode Island Hospital on 16 October 2007 to see the PCI program. Mr. Ross asked the applicant to provide data from Rhode Island Hospital regarding door to balloon times and numbers of primary angioplasties performed.

There being no further business the meeting was adjourned at 4:15PM.

Respectfully submitted,

Valentina D. Adamova, MBA
Health Economics Specialist